

have his treatment well under way before the doctor arrives.

Again, you find it alarming to note that 39% of patients had been given sedatives. As it has been standard teaching for years that there is a large psychological element in asthma it is surprising that a number of asthmatics are taking sedatives, regularly or intermittently, on the advice of doctors who are anxious to reduce the number of attacks of asthma? "Alarm" in any case seems rather a strong word to use when the dose of phenobarbitone in one proprietary tablet used by many asthmatics is only 8 mg. ($\frac{1}{4}$ gr.). The second of the two papers (p. 339) has the final word here—"that it does not seem likely that any drug other than corticosteroids or bronchodilators could have been responsible for the increase in mortality."

Finally, Sir, the misleading analogy with hypertension. Hypertension causes few symptoms even in those in whom it is causing serious harm, whereas asthma causes many symptoms even in those in whom it is causing little harm. Despite this you suggest that there should be "continual supervision with regular ventilatory tests." Suppose, Sir, that I spend 15 minutes, which is not much, every month doing this for each of my asthmatic patients. Can you tell me what other work I should abandon to free the extra 12 hours' work that this will entail every month?

I feel that if you are going to enlarge on an article as good as that from Dr. Speizer and his colleagues you should give us advice relevant to the treatment of asthma as it really affects the asthmatics in the community.—I am, etc.,

Southampton.

J. L. STRUTHERS.

SIR,—The hope is expressed in your excellent leading article (10 February, p. 329) that the increasing mortality from asthma might be reversed by wiser treatment even before the reasons for it are established. In particular, wider use of steroids, caution with aerosols, and closer supervision are advocated. To the extent that these aims refer to management of life-threatening episodes, I believe that they can be crystallized—for doctor and patient alike—into a simple plan of action.

Every asthma patient should be advised to contact the doctor as a matter of urgency if an aerosol inhaler, which has previously provided relief, suddenly fails to do so. Patients seem to have no difficulty in recognizing this change, which can be regarded (mechanical faults excepted) as an absolute indication for corticosteroid therapy, even if the chest signs and general condition do not appear to warrant it. In the absence of such a rule many asthmatic patients endeavour to avoid calling the doctor. There is then an appalling risk of increasing bronchiolar obstruction, while the patient progressively poisons himself with isoprenaline. Delay is thus another possible "toxic" effect of aerosol inhalers which might be added to those affecting the heart and lungs.

Whatever the cause of these deaths, which may after all have nothing to do with aerosols, it is clear that urgent intervention is often essential. In the study reported in the same issue (p. 335) about one-third of the patients died within two hours of the onset of the fatal episode. Of these, 90%

are known to have used aerosols, some of which very probably gave warning of the severity of the oncoming attack. It would be interesting to know how many of the patients noticed that their aerosols failed to provide relief not only during the final attack itself but also in the previous day or so. The Wright peak-flow meter can sometimes detect oncoming asthma hours or days before the patient himself becomes aware of it, and I suspect from my own limited experience that this may also be true of failure to respond to aerosol inhalations. Considerable investigation would of course be necessary to establish or refute these speculative points. But in the meanwhile no harm should come from adoption of the rule: failure to respond to a previously effective aerosol is an absolute indication for steroid therapy—intravenous, if necessary. At least some asthmatic children might be saved from untimely death.—I am, etc.,

Kings Langley,
Herts.

GEORGE F. B. BIRDWOOD.

Exercise after Infarction

SIR,—One of the world's greatest physicians, James Mackenzie,¹ made the following statement in 1918: "It may be laid down, as a general law, that every organ in the body is benefited by the exercise of its functions. The benefit does not accrue merely by the exercise at a low level, but by periods of increased efforts, followed by periods of comparative rest."

The writer of your leading article (4 November, p. 249) says: "A programme of graduated exercise is beneficial, but whether through the psychology of group therapy, better general fitness, or an actual improvement in myocardial perfusion is not yet known. Whatever the explanation there is no doubt that the patient with angina benefits greatly from this recently changed attitude towards exercise."

Mackenzie's observations—long forgotten—are now being rediscovered, although another leading cardiologist, K. F. Wenckebach, had formulated the same principles as Mackenzie in 1931.² Wenckebach's observations shared the same fate as Mackenzie's, which is unfortunate, since the increasing incidence of myocardial infarction has made it a problem of great medical and social importance. Of course a patient suffering from recent myocardial infarction should be treated with rest until a firm scar has been formed, though probably armchair nursing is to be preferred to rest in bed. It is, however, unreasonable to treat patients having angina of effort in the same way. In our opinion angina pectoris and intermittent claudication are symptoms of relative anoxaemia of functioning muscle tissue. In both diseases the value of physical exercises is beginning to get more attention, but up to now the effort of which the patient is capable is still measured by the maximum distance he is able to walk without getting pain. Any doctor who takes the trouble to walk with his patient himself can see that this is not the right method. In both diseases the initial tempo should be extremely slow, and is different for each patient, being found by trial and error. After a longer or shorter period, which also should be determined individually, the speed

may be increased gradually, until a maximum speed is reached with which the patient is able to walk a distance which is limited by fatigue only and not by pain.

A patient, 53 years old, suffered with angina. He had to stop work because he was unable to get to it. The distance concerned was 10 km., but the maximum distance he could cycle without getting angina was about one kilometre. On questioning he said that he never went alone, but always with one of his fellow workers. He was advised to go alone and to begin very slowly. He resumed work and told us that to his own astonishment he had no difficulty at all, and by beginning slowly he needed about the same travelling time as before.

After myocardial infarction the main difficulty in re-education is the absence of angina. There is a general tendency to find first the maximum effort of which the patient is capable—for example, on an ergometer bicycle—and to train him afterwards for longer periods on one-third of the maximum load. This way of thinking seems to us unphysiological and dangerous. On the contrary, no patient should exercise at maximum speed, not even experimentally and under electrocardiographic control. Moreover, to train on an ergometer bicycle is a tedious and unnatural way of training. Our method is to begin with exercises in bed, and when the patient is mobilized we take him walking. The initial speed, the period of adaptation, and the maximum speed is thus determined. Telemetric observations of every patient with a healed myocardial infarction may not be feasible, but pulse and respiration rate, absence of cyanosis, absence of pulse irregularities, blood-pressure readings, and the absence of accentuation of the second pulmonary sound are all valuable guides. If the physician will take the time to walk with his patients a few times he generally does not need elaborate methods to make an adequate training programme. He can use these simple objective observations as a measure of the patient's tolerance to exercise. In the same leading article you state: "Not everything that counts can be counted." This truism should be kept in mind when training the patient with ischaemic heart disease. If general practitioners and consultants were willing to observe their patients during walking much cardiovascular invalidism would be prevented.—We are, etc.,

J. SCHOUTEN.

Hilversum,
Holland.

J. TH. R. SCHREUDER.

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- ² Wenckebach, K. F., *Herz- und Kreislauf insuffizienz*, 1931. Dresden.

Epidemic Koro in Singapore

SIR,—Koro, well known among the Chinese as Shook Yong, is a belief that those afflicted with the disease experienced a sudden feeling of retraction of the penis into the abdomen with great fear that, should the retraction be permitted to proceed, and if help was not forthcoming, the penis would disappear into the abdomen with a fatal outcome. In their fear and anxiety to prevent such a mishap, they held on to the penis either with their hands or with instrumental aids, such as rubber-bands, strings, clamps,

chopsticks, clothes-pegs, etc., sometimes with severe injury to the penis.

This condition is well documented in Chinese literature, and described in many medical textbooks.¹⁻³ Sir Philip H. Manson-Bahr considered that the condition was originally described by Blonk in 1895.¹ He also described an analogous state in women, characterized by a sense of diminution of the labia and shrinkage of the breast.

In Singapore for many weeks in October and November 1967 there were widespread rumours that Koro was caused by eating the flesh of pigs recently vaccinated in a mass campaign to combat swine fever. This led to almost a standstill in the sale of pork in markets, eating stalls, and restaurants, and affection by Koro became epidemic. The Singapore Medical Association and the Ministry of Health had to allay the fears of the public in press conferences. The General Hospital outdoor clinic, which normally saw only a few cases a year, saw an average of 70-80 cases a day. The general practitioners in the private sector, who normally saw one or two cases during their years of practice, saw numerous cases during the epidemic.

A typical case was that of a 16-year-old school-boy who dashed into the clinic with his parents shouting for the doctor to attend to him quickly because he had "Shook Yong." The boy looked frightened and pale and he was pulling hard on his penis to prevent the organ from disappearing into his abdomen. The doctor explained and reassured both parents and patient. A tablet of 10 mg. of chlordiazepoxide was given at once and he was sent home with two days' supply of chlordiazepoxide. There was no recurrence. The boy had heard about Koro in school. That morning he took "Pow," which contained pork, for breakfast. Then he went to pass urine and noticed his penis shrunk at the end of micturition. Frightened, he quickly grasped the organ and rushed to his parents shouting for help.

A young mother rushed into the clinic holding on to her 4-month-old baby's penis and asking the doctor to treat her child quickly because he had Koro. The child had not been well for two days with cold and a little diarrhoea. The mother was changing his napkin and washing his perineum when the child had colic and screamed. The mother saw the penis getting smaller as the child screamed and thought he had Koro. She had previously heard the rumours. The mother was first reassured, and the baby's cold and diarrhoea treated. The child was all right after that.

The majority of the cases occurred in people less than 20 years old, and where children were affected this was due to the mothers' anxiety. The oldest case was a man of 40. All the cases seen during the epidemic by 12 general practitioners were Chinese, though isolated cases of other ethnic groups were seen in the general hospital outpatient clinic. Textbooks of tropical diseases mentioned that they appeared among the Macassars and the Buginese in Celebes and West Borneo. One general practitioner practising in a predominantly Malay district saw eight cases among the Malays and only two cases among the Chinese in his ten years of practice. Various occupational groups and married as well as single people were affected. All had previous knowledge of Koro. The onset usually followed a normal physiological cause of retraction and shrinking of the organ—for example, after a bath, after passing urine, after illnesses, etc.

Manson-Bahr and Strong¹⁻³ described it as a form of anxiety neurosis. Gwee⁴ described it as a cultural disease, an acute hysterical

panic reaction brought on by auto- or hetero-suggestion.—I am, etc.,

Singapore.

CHONG TONG MUN.

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- 1 Manson-Bahr, *Manson's Tropical Diseases*, 1960. London.
- 2 Sim, M., *Guide to Psychiatry*, 1963. Livingstone.
- 3 Strong, R. P., *Prevention and Treatment of Tropical Diseases*, 1945.
- 4 Gwee, A. L., *Singapore med. J.*, 1963, 4.

Mothers and Children in Hospital

SIR,—Mr. D. J. Brain and Miss Inga Maclay deserve our thanks for their report on the controlled study of mothers and children in hospital (3 February, p. 278), with its statistical demonstration of the physical and emotional benefits to certain children resulting from admission with them of their mothers. What is sad is that in this day and age such a demonstration should be necessary. It has never been felt necessary to demonstrate statistically that digitalis is of benefit to patients with heart disease—but what was needed was to define those patients with heart disease who would be helped by digitalis and the rules governing its use.

What those responsible for the care of children in hospital need to learn is how to decide when a mother should be admitted with her child, and what should be the environment into which they are admitted. The figures of Mr. Brain and Miss Maclay show that not all children are helped by having their mothers, and not all mothers would wish to repeat the experience. Although many children desperately need their mothers in hospital, with others the need is negligible, and there are instances where for emotional reasons it is essential temporarily to separate mother and child, although always with the aim of subsequent reunion. Again, it may be of the greatest help to a mother to be with her child, though on the contrary the experience may be extremely distressing to her. The effects on other members of the family must also be considered.

I shall not trespass on your space by attempting to describe what has been learnt of these matters over 40 years of experience of mothers in hospital in Newcastle. Suffice it to say that the decision about whether or not to advise a mother to come into hospital with her child is as important, and may be as difficult to reach, as any decision regarding his diagnosis and medical treatment. If a mother is to be admitted it is not sufficient to provide her with a bed. The greatest benefit to mother and child will occur only if the accommodation is planned to meet her needs as well as those of her child, and it seems that as yet few architects are aware of this.

Finally, the attitude of nursing staff is vital. The early success of the Babies' Hospital experiment in Newcastle was due in large measure to the personality of the matron, Miss Elizabeth Cummings, from whom I learnt much of what I know about mothers with their babies in hospital. I am not surprised that the nursing staff in Birmingham still prefer to nurse children without their mothers. Most girls who take up children's nursing do so with a very strong "mothering" instinct, and to prevent its fulfilment is to deprive the nurse of much of the satisfaction of her work. It is essen-

tial, therefore, that nurses in a unit admitting mothers must have also the care of children on their own, whom they can "mother." It is important also that the nursing staff accept the mothers as partners sharing their work and not as extra "patients" to be treated. There are now many units in this country where nursing staff are anxious to have mothers as members of their teams, either resident or as daily visitors, and it is in such units that the care of children in hospital is as near perfect as we can make it.—I am, etc.,

Cramlington,
Northumberland.

GEORGE DAVISON.

More Cases of Scabies

SIR,—I was interested in the observation of Drs. A. B. Shrank and Suzanne L. Alexander (17 February, p. 445) that the incidence of scabies at St. John's in London, and in Shropshire, continues to rise. It is likely, of course, that the incidence of this disease will show geographical variations.

On Teesside we have observed in this clinic until last year a similar epidemic pattern, with an annual continued increase in the number of cases referred. In 1967, however, there was for the first time in years a noticeable drop in the number of patients referred with scabies. The figures are as follows:

Year	No.	Percentage of Total Referrals
1963	94 cases	2.8 of 3,315 cases
1964	135 "	4.0 " 3,370 "
1965	229 "	7.1 " 3,224 "
1966	389 "	11.9 " 3,272 "
1967	216 "	6.8 " 3,182 "

(The numbers include contacts of patients actually referred.)

While these figures relate only to cases attending this department, they presumably reflect the incidence in the district. On this basis one can be hopeful that the epidemic in our area may in fact be abating, but I feel the suggestion by Drs. Shrank and Alexander that local authorities in general ought to consider the establishment of cleansing centres should be strongly supported. If our figures are going down it is largely because the vast majority of the patients were thoroughly treated under supervision in the dermatological department by a trained nursing staff (in my experience, treatment under such supervision is the only reliable method). This work, however, has placed a very heavy burden on an already busy unit, and may well have limited its scope for effort in other fields.

I would also agree that a more efficient method of treating contacts must be devised. With endless persuasion and cajolery, a certain number of contacts will attend for treatment under supervision, and a further number can be brought to treat themselves at home. But large numbers default, or cannot be persuaded to have treatment at all, and so the recurrence rate remains high, and in many areas the incidence of infection may continue to rise. A return to the days of notification of scabies would, in my opinion, be a great help to dermatological departments called upon to treat this disease (and would also help to establish its true incidence).—I am, etc.,

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